Verification of Direct Patient Care Experience
Associate Degree Nursing Program
LPN Work Experience

Student Authorization:

I hereby give permission for the release of information to the Associate Degree Nursing Program at Idaho State University – College of Technology.

Applicant Name (printed): _____

Signature: _____ Date: _____

Employer Verification:

Must be completed by HR or employer. Please complete the following information below regarding this employee. After completion, please return this form to the employee.

Facility Name:

Position held by Applicant:

Unit worked/description of unit:

Dates of Employment:

Total number of hours worked in direct patient care at this facility in the preceding 3 years:

Name and Position of individual completing this form:

_____

Signature: _____ Phone Number: _____

Date: _____